YOUTH SERVICES
FMLA RELEASE TO RETURN TO WORK

Employee: _____

Job Title: _____

Position Number: _____

TO: HEALTH CARE PROVIDER

Please review the above noted employee's Position Description and/or Essential Functions Form indicating the required physical conditions required in order to perform his/her job, and certify that he/she is or is not medically fit to return to work with / without restrictions.

(Check One)

□ _____ may return to work on _____ (date) with no restrictions.

□ _____ may return to work on _____ (date) with the following restrictions.

Restrictions:

_____

_____

_____

□ _____ may not return to work at this time.

Anticipated date employee should be medically fit to return to work: _____.

Employee may not return to work until health care provider certifies that he/she is medically fit to return to work. If the health care provider indicates the employee may only return to work with restrictions, the Agency will consider the restrictions and determine whether reasonable accommodations can be afforded to the employee.

_____ _____

Signature of Health Care Provider Date

_____

Print Name of Health Care Provider

c: PSS HR Employee FMLA File